Scheduling Information Sheet
Fax: 973-736-3588
Email: tracym@surgeryctr.com & priscillal@surgeryctr.com
NEED: Pre-Op Orders, SX Consent, H&P, Office notes, Medical Clearance

MOUNTAIN SURGERY CENTER

☐ **Transportation**

Surgeon: _____ **Scheduler:** _____

Co-Surgeon: _____ Assisting: _____

Scheduling Officer: _____

Date of Procedure: _____ **Length:** _____

Procedure: _____

Height: _____ Weight: _____ Gender: _____

CPT Codes: _____

ICD 10: _____

Special Needs: Diabetic Aspirin Coumadin Other: _____

Special Equipment: _____

Clearance Appt. Date, Time, Where: _____

CBC _____ UA _____ CMP_____ PT, PTT_____ CXR _____ EKG _____ H&P _____

Patient Name: _____

Address: _____

City: _____ **St:** _____ **Zip Code:** _____

Home Phone: **Cell Phone:** _____

Work Phone: _____ **DOB:** _____ **SSN:** _____

Patient Name (if minor): _____ Phone: _____

Primary Insurance: _____ Phone: _____

ID Number: _____ **Group Number:** _____

Secondary Insurance: _____ Phone: _____

ID Number: _____ Group Number: _____

Auto/Workers Comp: _____ Phone: _____

Adjuster: _____ Phone: _____

Claim/ Case #: _____

Claim Address: _____

Atty Office: _____ **Phone:** _____

Address: _____ **Contact Person:** _____

Accident Date: _____